Appendix III.

Prescription Drug Program Background Documents and Data

Appendix III. - Prescription Drug Program Background Documents and Data

Summary Overview of the Evidence-Based Review Process

OHSU EPC

- Manufacturers submit data
- Stakeholder input
- Literature Search
- Peer Review
- Draft Report released
- Stakeholder input and peer review
- Final Report

↓

PDP Staff

- Report distributed to P&T Committee and stakeholders
- 30 day notice of P&T Meeting
- MAA Supplemental Rebate bid request (must be received by MAA 7 days prior to meeting)

↓

P&T Committee

- Stakeholder input
- P&T Committee review and recommendation

↓

PDP Staff

- Review Supplemental Rebate bids
- Cost Analysis and recommendation to agency directors

↓

Agency Directors

- Final decision on Preferred Drug in reviewed class
- Notify Stakeholders, P&T Committee, and Endorsed Practitioners

↓

Preferred Drug List

- Implement

Appendix III. - Prescription Drug Program Background Documents and Data

Washington Prescription Drug Program's Preferred Drug Cost Analysis and Selection Process

(November 16, 2004)

I. Purpose:

To establish a consistent methodology for the Uniform Medical Plan, Medical Assistance Administration and Labor & Industries (the agencies) to use when selecting a preferred drug within a therapeutic class.

II. Scope:

This methodology applies to selection of preferred drugs for the drug classes to be included on the State of Washington Preferred Drug List (PDL). Drugs purchased through managed care contracts are not included in the analysis and are not within the scope of this document.

III. Background:

RCW 70.14.050 authorizes the agencies to collectively determine the preferred drug(s) in a class based on the scientific evidence of efficacy and safety. For drugs with similar efficacy and safety, but with no differences when considered in special populations, the agencies have developed the following process that determines which drug(s) in a class are the lowest net cost to the state of Washington.

IV. Determining the Average Daily Cost:

1) Each agency will keep a record of the average daily cost (ADC) (see formula below) and drug "unit" utilization for each drug in a class.

a. The third party will compute the ADC for each drug in the PDL class using the following steps:

b. Each state agency will provide the following data for each National Drug Code (NDC):
   i. NDC
   ii. Drug name
   iii. Units dispensed
   iv. Per unit ingredient price
   v. Per unit federal and state rebates (proprietary and confidential)
   vi. Days supplied

vii. Although not needed for the ADC calculation, each agency will also provide the number of scripts written by NDC for the computation of administrative costs and copay values described below

c. Total Net Cost by NDC is computed as Units x (Per Unit Ingredient Price – Per Unit Rebates).

d. Total Net Cost by candidate PDL drug is computed as the sum of total net costs by NDC for all NDCs for that PDL drug.

e. Total Days Supplied by candidate PDL drug is computed as the sum of all days supplied by NDC for all NDCs for that PDL drug.

f. ADC for each candidate PDL drug is computed as total net cost divided by total days supplied.

- The prices used to compute the ADC will be the most recent available, for example MAA prices are updated on a weekly basis.

- Utilization information will be based on the most recent 12-24 months of utilization data available. After the initial PDL determinations are made, updates will be based on the most recent available calendar quarter of data.

- Agency staff recognizes that historical utilization data may not reflect future trends for many reasons, among them significant price changes, impact on the market of new entries within a particular or related category of drug, and patent status changes. Agency staff also recognizes that historical information, absent other information, is the best predictor of future utilization given that actuarial and other technical adjustments are made as required.

- Utilization data for a new generic will use the associated brand's utilization as a proxy for the generic equivalent in PDL selection and potential net savings calculations.

- Utilization data will be used in the recommendation process for two basic purposes: First, to model relative shares of individual NDC demand within each drug; e.g. the use of 5mg tabs rather than 20mg tabs of a particular drug. Second, the data will provide an initial basis to estimate savings to the State under various scenarios.

2) MAA's average daily cost calculations for brand name (and certain generic) drugs include:

- State and federal rebate amounts paid for the drug(s); and
- A Maximum Allowable Cost (MAC) which may be set for generic and brand drug(s). MAC means the maximum amount that the MAA pays for a specific dosage form and strength of a multiple-source drug product.
- The following principles will guide MAA's ranking of a drug that has a MAC (Automated Maximum Allowable Cost (AMAC), State Maximum Allowable Cost "SMAC", or Federal Upper Limit "FUL"):
- Generics with or without a MAC will be included in Exhibit 1 and 2 when it will encourage equally effective and less costly utilization.
- Brand name drugs with a MAC will be included in Exhibit 1 however not included in the PDL selection when it will negatively affect the MAC program by increasing the number of MAC waivers.
- MAA – Division of Medicaid Management (DMM) pharmacy staff will announce future PDL classes to MAA – Division of Business and Finance (DBF) pharmacy staff in advance of the PDL selection in order to allow them to research and set state MAC prices where possible.

3) MAA, UMP, and L&I will send their respective average daily cost information to an agreed upon third party to maintain contractually required unit pricing confidentiality for analysis.

V. Determining the Lowest Net Cost to the State:

1) The third party will model administrative (Prior Authorization (PA)) costs, Co-Payments (where applicable), substitution and intra-agency pricing differentials for each drug.

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a. The administrative cost assumptions and methodology are as follows:

   For MAA and L&I, PA administrative costs have been estimated at $15 and $20 per call, respectively. These estimates are based on analysis performed by MAA and vendor pricing provided by L&I. Using actual call frequencies and prescription counts for the period April 2004 – July 2004 provided by MAA, the third party correlated the PA frequency to the number of non-preferred scripts (where the number of PA calls was approximately 20% of the number of non-preferred scripts). Administrative costs are estimated as the number of non-preferred scripts multiplied by 20% and then multiplied by the per call charge.

   No administrative costs are included for UMP.

b. The Co-Payment assumptions and methodology is as follows:

   ADC amounts are reduced by modeled co-payments. For each NDC, UMP provided an assumption of retail or mail order, from which it was assumed that retail drugs were prescribed in a 30 day supply and mail order drugs were prescribed in a 90 day supply. The Total Days Supplied was also provided, which combined with the days prescribed assumption, allowed for the estimation of the number of scripts written. The actual number of scripts written will be included in the data extract sent to the third party. Co-payment rules by tier and by retail/mail order were then applied to each drug.

   No co-payment reductions were applied to MAA or L&I.

c. The substitution and intra-agency pricing differential impacts are as follows:

   For each PDL scenario, those non-preferred drugs that shift to preferred drugs are assumed to do so in proportion to the relative historical utilization of preferred drugs separately for each agency. For MAA, the percentage of non-preferred drugs assumed to shift to preferred drugs in the savings estimate is based on recent historical levels of preferred drug utilization in the four classes with such history. The two classes for which the PDL is new (skeletal muscle relaxants and urinary incontinence drugs) have assumed a 70% migration of non-preferred to preferred drugs (a percentage slightly better than long-acting opioids). For Estrogens, PPIs and Statins a 90% migration assumption has been used.

Substitution for UMP assumes no movement of non-preferred generics and 50% movement of non-preferred brand name drugs.

Substitution for L&I is assumed to mimic MAA.

Intra-agency pricing differentials are considered in the model as drugs in each class are ranked according to the composite average cost for all three agencies combined. This composite ADC uses historical utilization by agency as weights in this computation.

2) The third party will incorporate these impacts into the ADC to construct an adjusted or net cost ADC for each drug, for each agency. The assumptions and methodology for the adjustment is as follows:

The model considers the co-payment adjusted UMP expenses as part of the initial ranking of drugs by class. Administrative costs and substitution rates are considered as part of the savings estimates associated with each PDL scenario by drug class.

3) The third party will, for each drug class and agency, rank order the ADC for each drug using a weighting relative to the lowest cost drug in a class, again assuring that federal and supplemental rebates are not disclosed.

Formula for weighting: Relative weight (RW) = (ADC for a Drug) / (ADC lowest drug)

4) The results will be arrayed from lowest cost to highest cost subject to the following categorical criteria. Within each therapeutic class, each drug will have a PDL eligibility status defined as one of the following five options:

1. Required for inclusion on the preferred drug list. In most cases this situation is the direct result of a P&T Committee decision (e.g. Lipitor®). It can also result from linkage to other contractual arrangements that make it financially impractical to offer any PDL that excludes the drug (e.g. Imitrex®).

2. Eligible for PDL inclusion. Generics and non-MAC brands are generally eligible for PDL inclusion (e.g. lovastatin).

3. Brands subject to MAC are identified and assumed not eligible for PDL inclusion (e.g. Mevacor®).

4. Excluded Drugs. Drugs identified by the P&T Committee as being excluded from eligibility for the PDL (e.g. Crestor®). These drugs are expected to have a very selective PA and minimal utilization.

5. P&T Committee selected drugs for specific medical conditions. Similar to Status 1 drugs in that the P&T Committee has directed their inclusion. However, these drugs differ in the model because they address a specific medical condition (e.g. Pravachol®). Therefore, the model assumes their inclusion in the PDL but excludes them from any utilization shifting assumptions as part of the savings estimates.

This status identifier (1-5) will be provided by MAA and is included in Exhibit I for each drug, which ranks drugs by status and the all agency combined ADC.

5) The results will be displayed in a format similar to the example below (See table #1)

Exhibit 1: Average Daily Costs Rankings

Drug Class/Status	Average Daily Agency Costs Rankings*				Annualized Days Supplied			
	MAA	UMP	L&I	Combined	MAA	UMP	L&I	Combined
Drug/ 1								
Drug/ 2								
Drug/ etc.								

*** Exclusive of dispensing fees and pharmacy charges; inclusive of federal and state rebates. The ADC calculations include UMP co-payments.**

VI. Decision Methodology to Choose Preferred Drugs in a Class:

While having a single preferred drug in a class will usually result in the lowest net cost to the state, other issues related to agency business needs, clinical and P&T Committee requests, WAC's and RCW may require increasing the number of drugs in a preferred class.

Agency staff recognizes that these constraints, clinical information and common sense will require that adjustments be made on a drug by drug basis. All drugs on the PDL must:

- ∉ Be among the categories of drugs that have been reviewed by the Oregon Health & Sciences University Drug Effectiveness Review Project that in which Washington participates.

- Be ranked consistent with any direction given by the Washington State P & T Committee.
- Exclude brands with generics that have an MAC for the calculations of ADC.

For all drugs within a class that meet the above initial selection requirements the agency staff shall use the tabular data described above and two summary exhibits created by the third party to assist in the decision process. Those exhibits are as follows:

- Exhibit I will display the ranking of drugs using the RW- ADC price of each drug and the historical utilization for that drug.

In situations where new drugs or other changes will impact future utilization those shall be noted and any adjustments documented.

In situations were the P & T Committee has made specific recommendations for specific drug(s), they will be added to the top of the list.

- Exhibit II will display the results of a savings impact analysis by conducting a savings impact analysis using the adjusted ADCs with offsets for administrative costs.

Exhibit II shows the agency savings, administrative costs and net savings to the state by adding an additional drug in order from the lowest to the highest net cost generic. Subtracting the agency administrative costs from the gross agency savings results in net agency savings. Combining each agency determines net state savings. The drug(s) resulting in the highest net state savings is moved forward for PDL Selection.

In situations where new drugs or other changes will impact future utilization those shall be noted and any adjustments documented based on brand equivalent utilizations.

The third party shall report saving impacts, again assuring unit cost confidentiality.

Appendix III. - Prescription Drug Program Background Documents and Data

Exhibit 2: Savings Relative to Increasing Access to Generic/Brand and Switching

Drug	SAVINGS						
	State	Gross Savings			–Net Savings		
	WA	MAA	UMP	L&I	MAA	UMP	L&I
Drug							
Drug							
Drug							
Drug							

*** Savings assume difference between shifting percentage of non-preferred drugs to preferred.**

VII. Agency Staff Recommendations on Preferred Drugs:

Agency staff recommendations of preferred drugs will be based on reviews of:

- The data presented for cost analysis.
- The methodologies and assumptions used in the cost analysis.
- Buying access assumptions (e.g. % brand/generic).
- Consistency with DUR/P&T/Clinical requirements.

Agency staff will make preferred drug recommendations to agency heads using information from these deliberations to determine the lowest net cost to the State.

Agency staff will produce a recommendation summary that includes the following information for each drug class reviewed by the P&T Committee:

- A list of drugs in the therapeutic class under consideration, both generic and brand name.
- A copy of the P&T Committee motion and recommendation for the drug class.
- A recommendation as to the specific drug, or drugs to be included as preferred in the class.
- A summary table representing the combined cost analysis data contained in exhibits 1 and 2 above, with proprietary and confidential MAA rebate information redacted (Exhibit 3 below):

Appendix III. - Prescription Drug Program Background Documents and Data

Exhibit 3: Summary Cost Analysis by Drug Status/Relative Daily Cost

Status	Drug Class	Days Supply*				Relative Daily Cost -Net Copays
	Drugs	MAA	UMP	L&I	Combined	Combined
	Total -					

*** note on data used to calculate days supply**

Agency heads will determine the preferred drug(s) in a therapeutic class based on the agency staff analysis and recommendations.

The agency staff recommendation summary that has had all proprietary and confidential information redacted (Exhibit 3) will be a public document.

The P & T Committee will update its review and recommendations with regard to drug classes included on the PDL at least annually.

Appendix III. - Prescription Drug Program Background Documents and Data

Prescription Drug Program Agency Staff Analysis and Recommendations:

Proton Pump Inhibitor Drug Class 10/29/2004

Drugs in class

Generic	Brand
esomeprazole	Nexium®
lansoprazole capsule, powder	Prevacid®
lansoprazole solutab	P[illegible] Sol[illegible]Tab®
omeprazole capsules	[illegible]ilosec
omeprazole tablets	[illegible]ilosec [illegible]TC
pantoprazole	[illegible]otonix
rabeprazole	A[illegible]iphex

P&T Committee recommendati[illegible]s

After considering the evide[illegible]e of safet[illegible]ffica[illegible]y [illegible]nd sp[illegible]cial populat[illegible], I move that rabeprozole, omepr[illegible]zole, la[illegible]prazole, [illegible]a[illegible]top[illegible]zo[illegible], an[illegible]esomeprazole are safe, efficacious and ha[illegible] no diff[illegible]ces in a[illegible]ve[illegible]e [illegible]ven[illegible] in [illegible]ecial populations. They can be subject to t[illegible]erapeu[illegible]c interc[illegible]n[illegible] in the Wa[illegible]i[illegible]gton [illegible]ref[illegible]red drug list. A pediatric formul[illegible]ion [illegible]eeds [illegible]o be incl[illegible]ded [illegible]n the [illegible]Vash[illegible]gton [illegible]eferred Drug List. [Reese, Bray 2nd [illegible]ed u[illegible]nir[illegible]ous, Whi[illegible] abs[illegible]t.]

[illegible]ost analysis

Status	PPIs	Days Supply*				Relative Daily Cost -Net Copays
	Drug	MAA	UMP	L&I	Combined	Combined
2	PRIL[illegible]SEC OTC	2,601,404	86,266	22,744	2,710,414	1.00
2	PREV[illegible]CID C[illegible]AP[illegible]ULE	2,471,202	306,030	35,222	2,812,454	1.59
2	PROT[illegible]NI[illegible]	4,799,606	519,614	29,976	5,349,196	2.00
2	ACIPH[illegible]	0	147,072	7,450	154,522	3.38
2	NEXIUM	992,210	490,948	30,058	1,513,216	4.03
2	OMEPRAZOLE RX	163,612	683,982	16,372	863,966	4.50
3	PRILOSEC	68,408	59,724	6,554	134,686	7.63
5	PREVACID POWDER	0	1,640	0	1,640	4.08
5	PREVACID SOLUTAB	56,270	1,102	0	57,372	4.64
	Total - PPIs	*11,152,712*	*2,296,378*	*148,376*	*13,597,466*	

* **Days Supply derived from February 2004 – July 2004 experience, annualized**

Appendix III. - Prescription Drug Program Background Documents and Data

Agency Staff recommendations

After reviewing P&T recommendations and conducting a cost analysis the s
recommends the following drugs to be preferred on the Washington PDL:

omeprazole tablets (Prilosec OTC ®)
lansoprazole tablets (Prevacid Solutab®)*
lansoprazole capsules (Prevacid®)
lansoprazole powder (Prevacid®)*

*** subject to expedited prior authoriza on for ecial po lati s (pediatric/swallowing difficulties).**

KEY TO DRU STA US N BERS

1. Required for inclusio on the pr ed ug ist. most cases s situation is the direct result f a P&T ommitt cisi n (e g. L pitor®). It can also result from linkage to o er cont ct al arra ge. en s th ma e it financially impractical to offe any PDL that ex lud s the d ug (e Imi ex®

   Eligibl for PDL incl sion. ene cs an non-MAC brands are generally eligible for PDL usion (e. lov in)

3. Brands sub to MA are ide ified and assumed not eligible for PDL inclusion (e g. Meva or

   Excluded rugs. rugs identified by the P&T Committee as being excluded from eligibility or the PDL (e.g. Crestor®). These drugs are expected to have a very selective A and minimal utilization.

5. Committee selected drugs for specific medical conditions. Similar to tatus 1 drugs in that the P&T Committee has directed their inclusion. However, these drugs differ in the model because they address a specific medical condition (e.g. Pravachol®). Therefore, the model assumes their inclusion in the PDL but excludes them from any utilization shifting assumptions as part of the savings estimates.

Appendix III. - Prescription Drug Program Background Documents and Data

Progress Report on Implementation of SB 6088

Exhibit 1

Percent of Prescriptions on Preferred PDL Drugs Dispensed

Provider compliance with the PDL varies by drug class and agency. The UMP allows its members a choice to pay a higher coinsurance or copay for a non preferred drug if they choose, which affects their rate of compliance to the PDL. Note the UMP compliance varies from a high of 91% in ACE Inhibitors to 21% in Long Acting Opioids.

Estrogens are not included in the MAA data as that drug class was implemented on December 1, 2004.

Of the twelve drug classes on the PDL, only five apply to L&I - Worker's Compensation: Long Acting Opioids; Skeletal Muscle Relaxants; Non-Steroidal Anti-inflammatory Drugs; Proton Pump Inhibitors; and Urinary Incontinence Drugs.

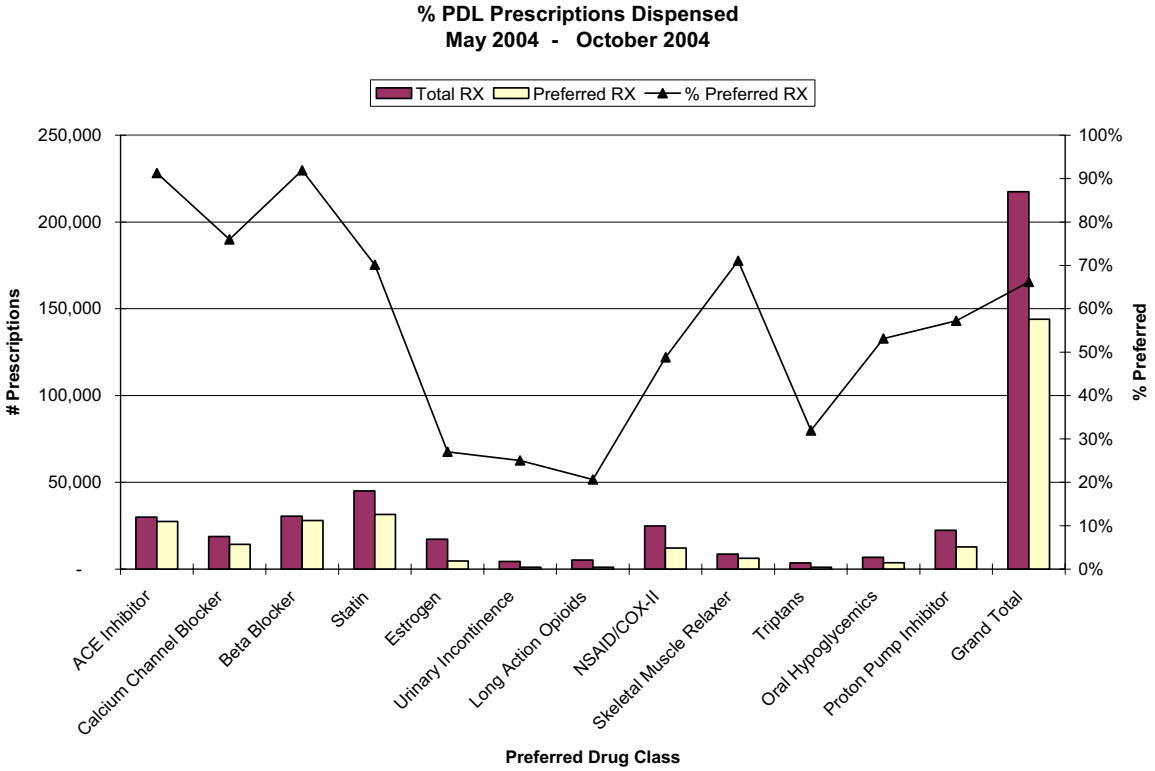
Appendix III. - Prescription Drug Program Background Documents and Data

HCA - Uniform Medical Plan

Table 1

Drug Class	Total RX	Preferred RX	% Preferred RX
ACE Inhibitor	29,973	27,356	91%
Calcium Channel Blocker	18,792	14,280	76%
Beta Blocker	30,448	27,979	92%
Statin	45,041	31,600	70%
Estrogen	17,129	4,631	27%
Urinary Incontinence	4,373	1,094	25%
Long Action Opioids	5,297	1,094	21%
NSAID/COX-II	24,892	12,143	49%
Skeletal Muscle Relaxer	8,687	6,174	71%
Triptans	3,592	1,147	32%
Oral Hypoglycemics	6,824	3,626	53%
Proton Pump Inhibitor	22,393	12,816	57%
Grand Total	**217,441**	**143,940**	**66%**

Figure-1:



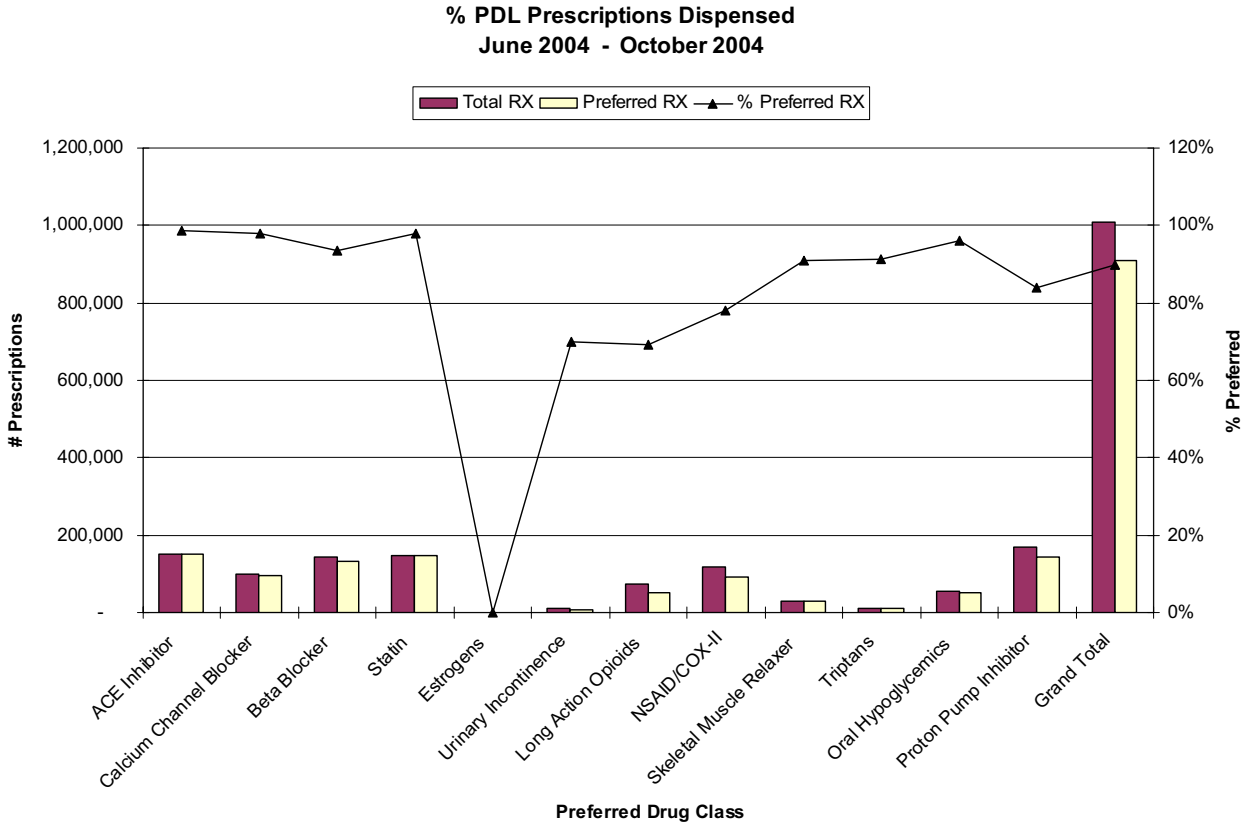
Appendix III. - Prescription Drug Program Background Documents and Data

DSHS – Medical Assistance Administration

Table-2

Drug Class	Total RX	Preferred RX	% Preferred RX
ACE Inhibitor	151,405	149,275	99%
Calcium Channel Blocker	98,639	96,424	98%
Beta Blocker	142,552	133,515	94%
Statin	149,054	145,700	98%
Estrogens	-	-	0%
Urinary Incontinence	11,850	8,295	70%
Long Action Opioids	73,132	50,559	69%
NSAID/COX-II	118,224	92,158	78%
Skeletal Muscle Relaxer	31,034	28,216	91%
Triptans	10,453	9,525	91%
Oral Hypoglycemics	53,639	51,445	96%
Proton Pump Inhibitor	169,590	142,271	84%
Grand Total	**1,009,572**	**907,383**	**90%**

Figure-2



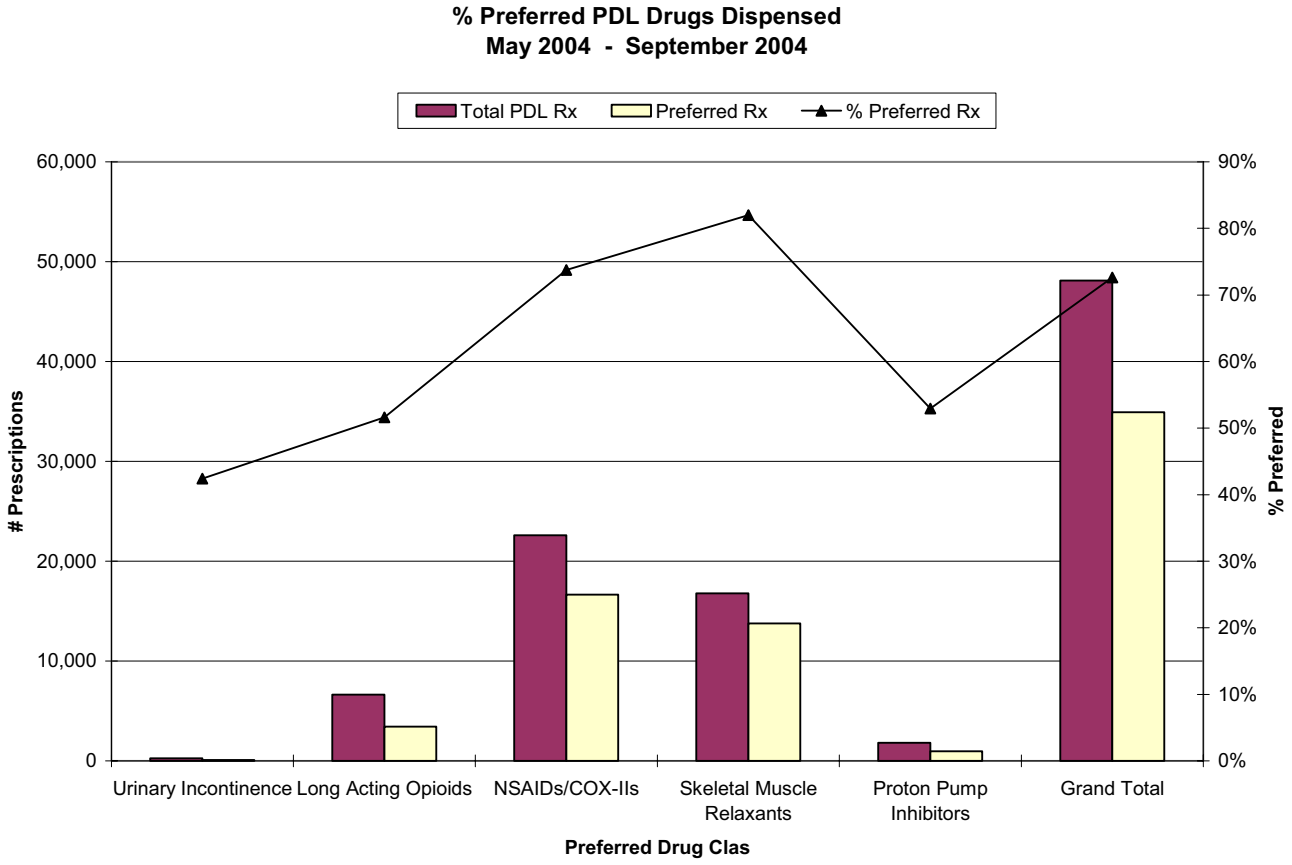
Appendix III. - Prescription Drug Program Background Documents and Data

L&I – Worker's Compensation Program

Table-3

Drug Class	Total PDL Rx	Preferred Rx	% Preferred Rx
Urinary Incontinence	250	106	42%
Long Acting Opioids	6,641	3,427	52%
NSAIDs/COX-IIs	22,600	16,669	74%
Skeletal Muscle Relaxants	16,789	13,765	82%
Proton Pump Inhibitors	1,833	970	53%
Grand Total	**48,113**	**34,937**	**73%**

Figure-3



Appendix III. - Prescription Drug Program Background Documents and Data

Exhibit 2

Percent of Prescriptions on Preferred Drug List signed Dispense as Written

The percent of prescriptions written by providers requesting dispense as written for the three agencies varies from 12%-30%.

The Long Acting Opioids have a high incidence of DAW. Although TIP has been implemented for this class, conversion has been slow. Federal law requires that a pharmacist receive a new paper prescription in order to dispense these medications.

Appendix III. - Prescription Drug Program Background Documents and Data

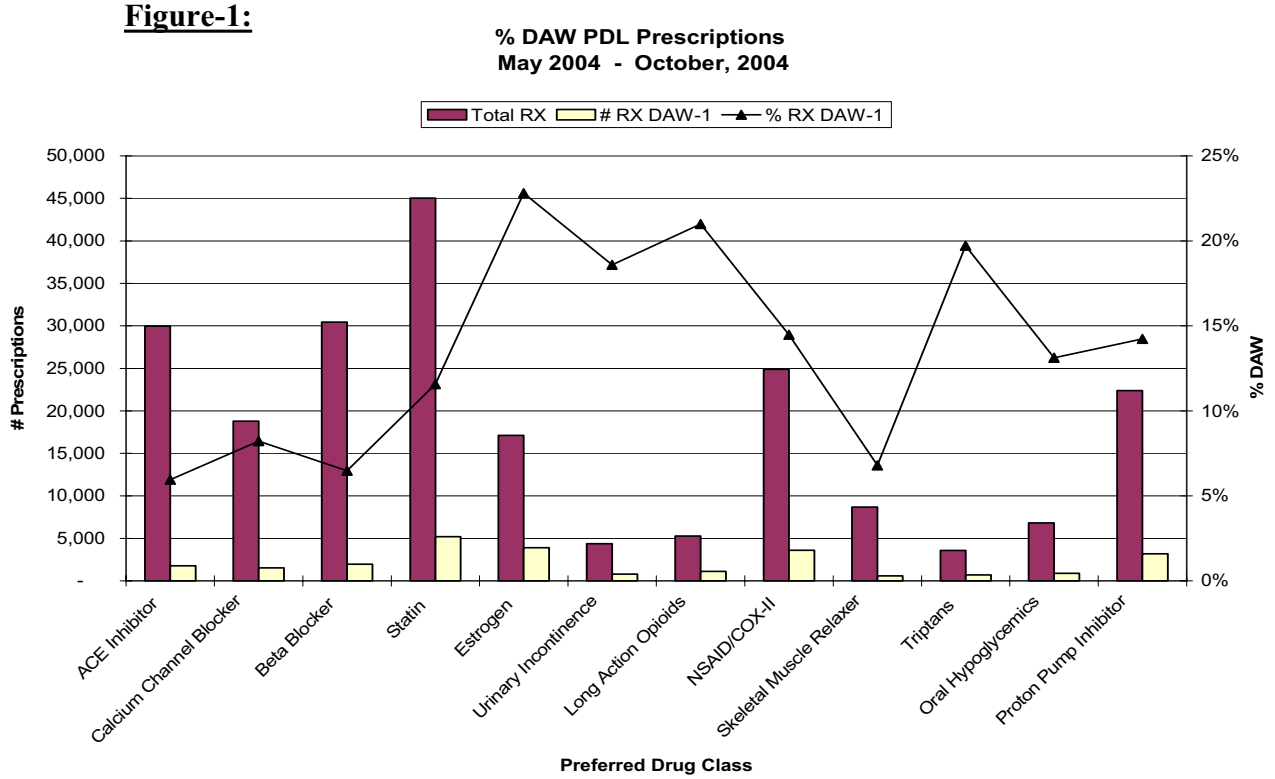
HCA - Uniform Medical Plan

Table 1

Drug Class	Total RX*	# RX DAW-1	% RX DAW-1
ACE Inhibitor	29,973	1,786	6%
Calcium Channel Blocker	18,792	1,544	8%
Beta Blocker	30,448	1,973	6%
Statin	45,041	5,210	12%
Estrogen	17,129	3,907	23%
Urinary Incontinence	4,373	813	19%
Long Action Opioids	5,297	1,112	21%
NSAID/COX-II	24,892	3,605	14%
Skeletal Muscle Relaxer	8,687	590	7%
Triptans	3,592	708	20%
Oral Hypoglycemics	6,824	896	13%
Proton Pump Inhibitor	22,393	3,187	14%
Grand Total	**217,441**	**25,331**	**12%**

***Total of all prescriptions regardless of endorsing status of the prescriber**

Figure-1:



Appendix III. - Prescription Drug Program Background Documents and Data

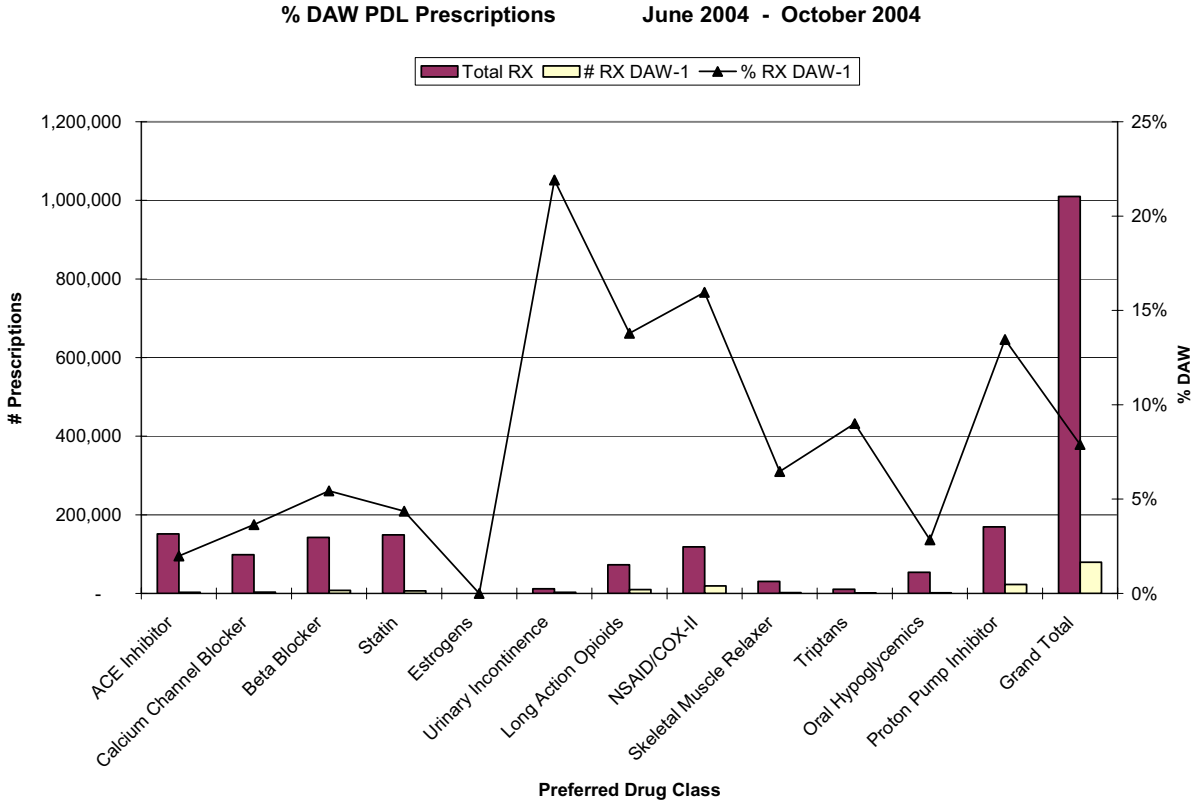
DSHS – Medical Assistance Administration

Table-2

Drug Class	Total RX *	# RX DAW-1	% RX DAW-1
ACE Inhibitor	151,405	3,013	2%
Calcium Channel Blocker	98,639	3,599	4%
Beta Blocker	142,552	7,756	5%
Statin	149,054	6,500	4%
Estrogens	-	-	0%
Urinary Incontinence	11,850	2,596	22%
Long Action Opioids	73,132	10,083	14%
NSAID/COX-II	118,224	18,872	16%
Skeletal Muscle Relaxer	31,034	2,008	6%
Triptans	10,453	941	9%
Oral Hypoglycemics	53,639	1,523	3%
Proton Pump Inhibitor	169,590	22,830	13%
Grand Total	**1,009,572**	**79,721**	**8%**

***Total of all prescriptions regardless of endorsing status of the prescriber**

Figure-2



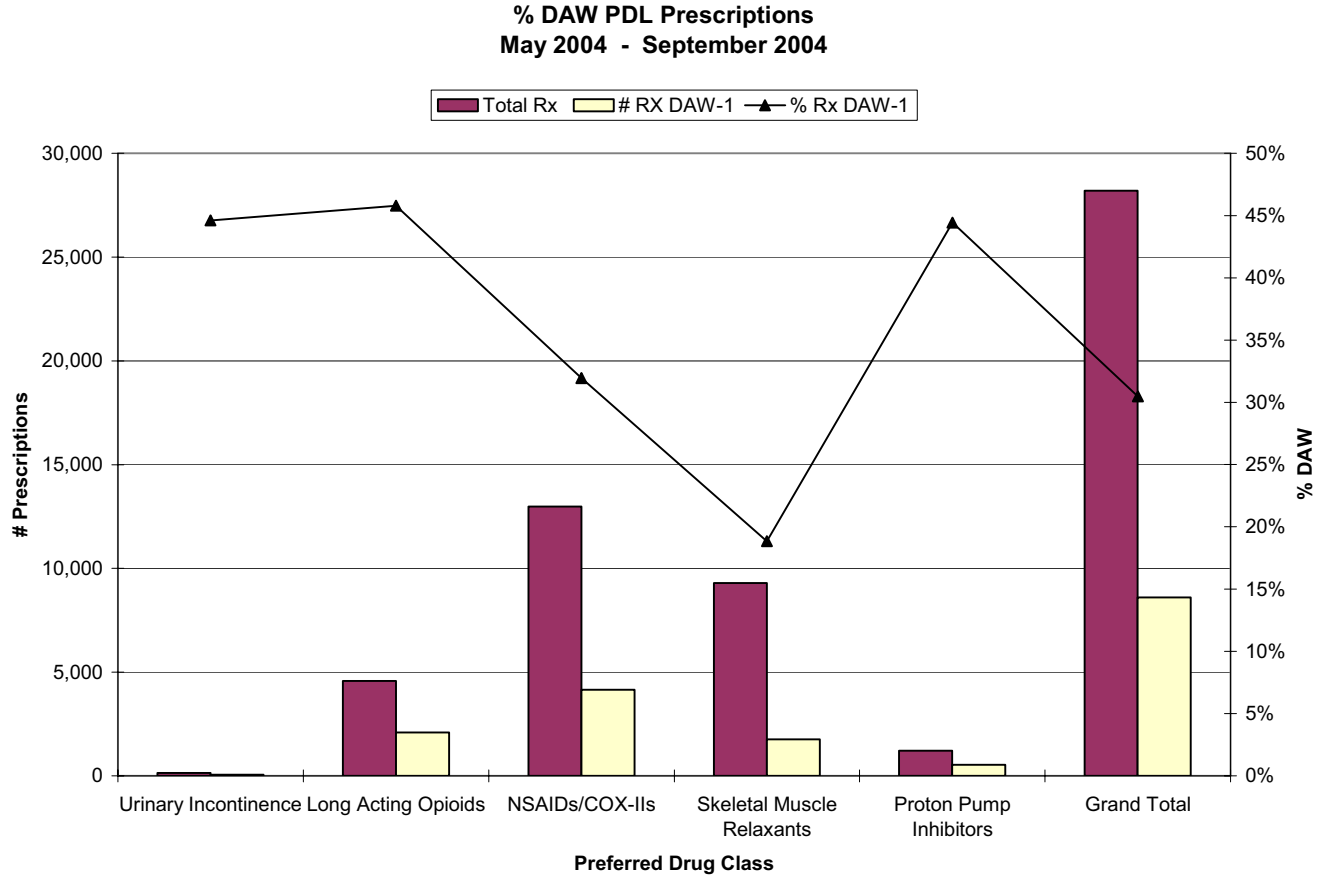
Appendix III. - Prescription Drug Program Background Documents and Data

L&I – Worker's Compensation Program

Table-3

Drug Class	Total Rx by Endorsing Practitioner	# RX DAW-1	% Rx DAW-1
Urinary Incontinence	139	62	45%
Long Acting Opioids	4,572	2,094	46%
NSAIDs/COX-IIs	12,983	4,148	32%
Skeletal Muscle Relaxants	9,295	1,751	19%
Proton Pump Inhibitors	1,213	539	44%
Grand Total	**28,202**	**8,594**	**30%**

Figure-3



Appendix III. - Prescription Drug Program Background Documents and Data

Exhibit 3

Percent of Prescriptions on Preferred Drug List Prescribed by Endorsing Practitioners

There is a large discrepancy between the UMP and the two other agencies in measuring the percent of prescriptions on the PDL prescribed by endorsing practitioners. This difference is most likely due to the inability of the prescription claims processing system, used by UMP's pharmacy benefit manager, to identify endorsing practitioners by means other than the prescriber's Drug Enforcement Agency (DEA) number. Since the percentage of endorsing practitioners for MAA and L&I is similar we believe this accurately reflects the participation of our providers. We believe having over half of the providers participating in the endorsing practitioners program is a measurement of success in recruiting them to participate.

Appendix III. - Prescription Drug Program Background Documents and Data

Exhibit 3

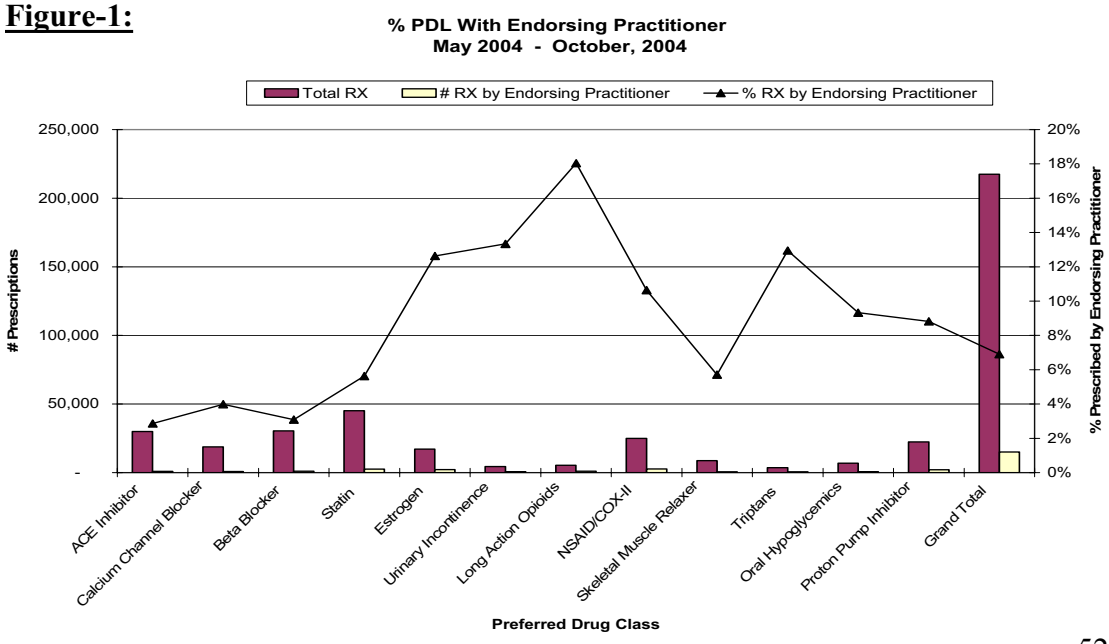
Percent of Prescriptions on Preferred Drug List Prescribed by Endorsing Practitioners

HCA - Uniform Medical Plan

Table 1

Drug Class	Total RX	No. RX by Endorsing Practitioners	% RX by Endorsing Practitioners
ACE Inhibitor	29,973	856	3%
Calcium Channel Blocker	18,792	748	4%
Beta Blocker	30,448	941	3%
Statin	45,041	2,537	6%
Estrogen	17,129	2,163	13%
Urinary Incontinence	4,373	583	13%
Long Action Opioids	5,297	956	18%
NSAID/COX-II	24,892	2,648	11%
Skeletal Muscle Relaxer	8,687	496	6%
Triptans	3,592	465	13%
Oral Hypoglycemics	6,824	636	9%
Proton Pump Inhibitor	22,393	1,974	9%
Grand Total	**217,441**	**15,003**	**7%**

Figure-1:



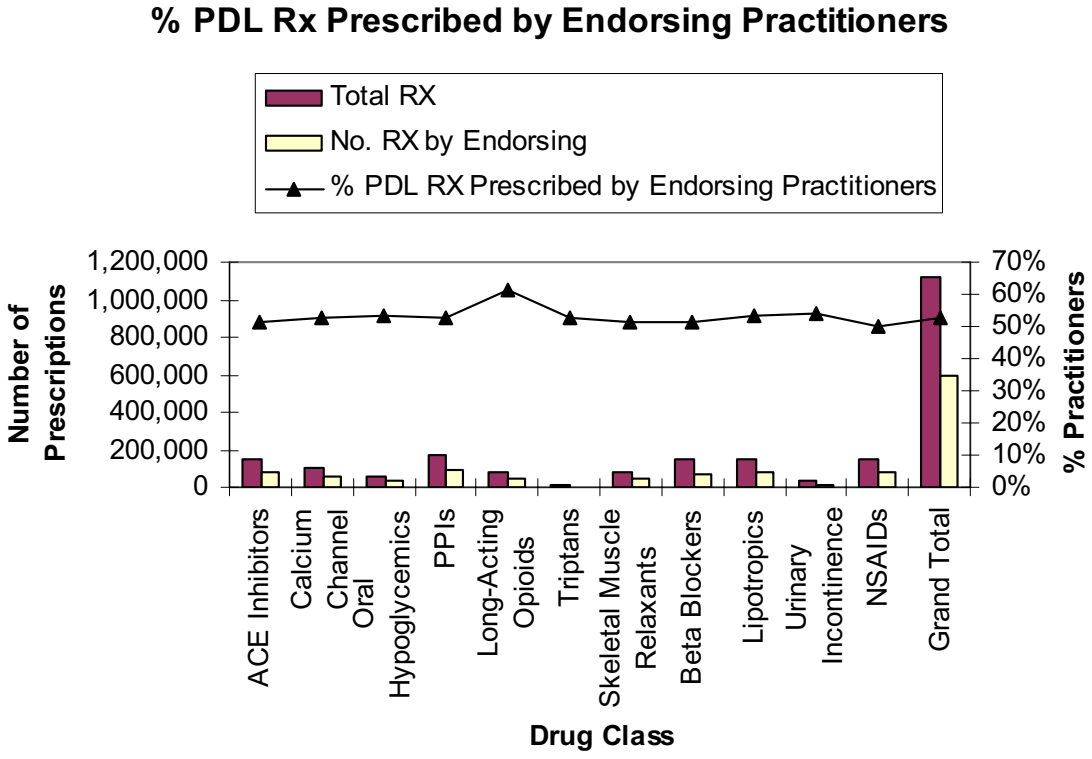
Appendix III. - Prescription Drug Program Background Documents and Data

DSHS – Medical Assistance Administration

Table-2

Drug Class	Total RX	No. RX by Endorsing Practitioners	% PDL RX Prescribed by Endorsing Practitioners
ACE Inhibitors	152,820	78,592	51%
Calcium Channel Blockers	99,520	52,623	53%
Oral Hypoglycemics	54,158	28,921	53%
PPIs	170,570	90,288	53%
Long-Acting Opioids	74,416	45,683	61%
Triptans	10,462	5480	52%
Skeletal Muscle Relaxants	83,614	43,029	51%
Beta Blockers	144,127	73,575	51%
Lipotropics	149,994	79,660	53%
Urinary Incontinence	31,529	16,986	54%
NSAIDs	151,895	75,766	50%
Grand Total	**1,123,105**	**590,603**	**53%**

Figure-2



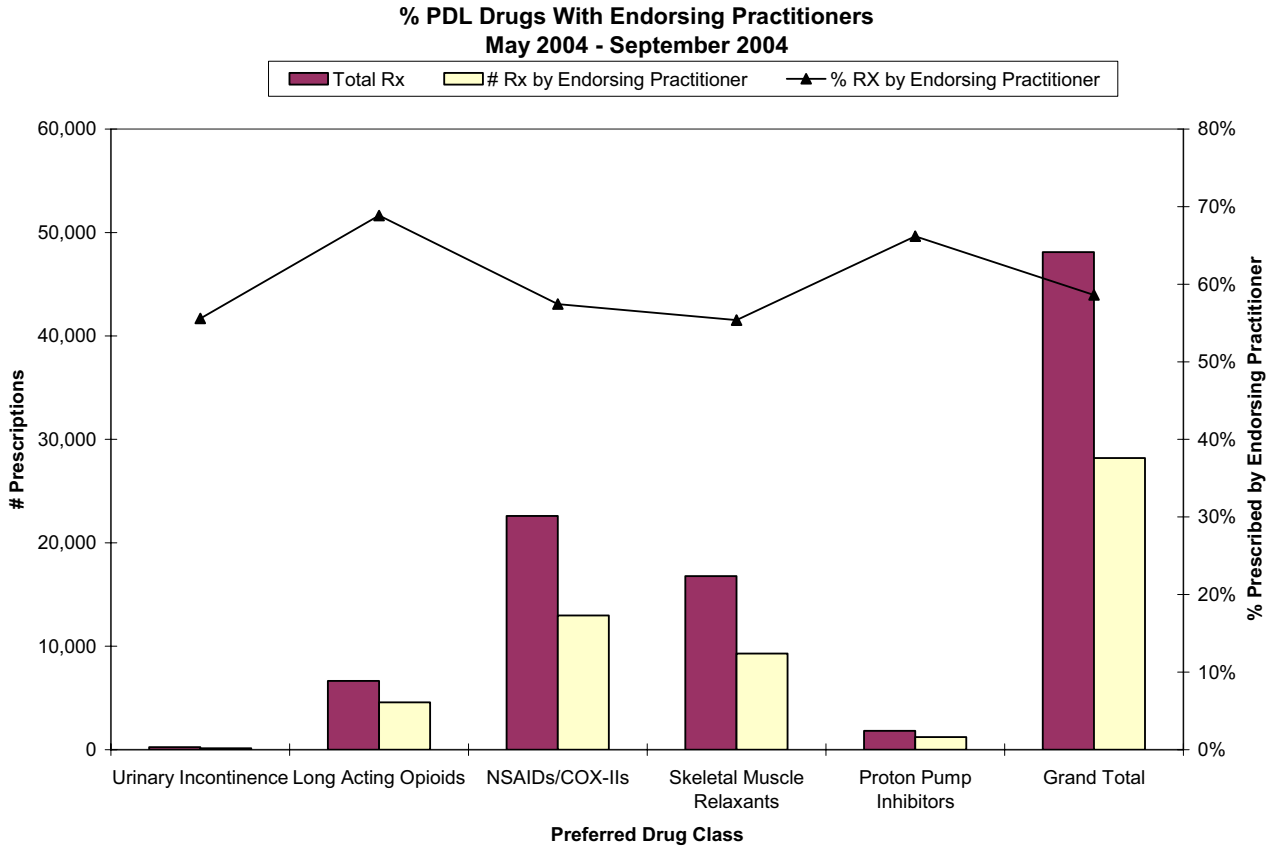
Appendix III. - Prescription Drug Program Background Documents and Data

L&I – Worker's Compensation Program

Table-3

Drug Class	Total Rx	No. Rx by Endorsing Practitioners	% RX by Endorsing Practitioners
Urinary Incontinence	250	139	56%
Long Acting Opioids	6,641	4,572	69%
NSAIDs/COX-IIs	22,600	12,983	57%
Skeletal Muscle Relaxants	16,789	9,295	55%
Proton Pump Inhibitors	1,833	1,213	66%
Grand Total	**48,113**	**28,202**	**59%**

Figure-3



Appendix III. - Prescription Drug Program Background Documents and Data

Washington State Preferred Drug List
as of December 2004

Musculoskeletal & Pain Medications

Nonsteroidal anti-inflammatory drugs (NSAID)
Cyclo-oxygenase - 2 (Cox-II) inhibitors

NONPREFERRED BRAND NAME DRUGS	PREFERRED GENERIC ALTERNATIVES
Anaprox/DS (naproxen Sodium)	diclofenac potassium
Bextra (valdecoxib)	diclofenac sodium
Cataflam (diclofenac potassium)	etodolac/XL
Celebrex (celecoxib)	ibuprofen
Clinoril (sulindac)	ketoprofen
Daypro (oxaprozin)	nabumetone
Feldene (piroxicam)	naproxen/sodium
Lodine/XL (etodolac)	oxaprozin
Mobic (meloxicam)	piroxicam
Motrin (ibuprofen)	salsalate
Naprosyn/DS (naproxen)	sulindac
Orudis (ketoprofen)	
Oruvail (ketorprofen)	
Relafen (nabumetone)	
Salflex (salsalate)	
Voltaren/XL (diclofenac sodium)	

Skeletal Muscle Relaxers

NONPREFERRED GENERIC DRUGS	PREFERRED GENERIC ALTERNATIVES
carisoprodol	baclofen
orphenadrine	chlorzoxazone
tizanidine	cyclobenzaprine
	methocarbamol

NONPREFERRED BRAND NAME DRUGS

Dantrium (dantrolene)
Flexeril (cyclobenzaprine)
Lioresal (baclofen)
Norflex (orphenadrine)
Parafon Forte (chlorzoxaxone)
Robaxin (methocarbamol)

Skelaxin (Metaxalone)
Soma (carisoprodol)
Zanaflex (tizanidine)

Long Acting Opioids

NONPREFERRED GENERIC DRUGS	PREFERRED GENERIC ALTERNATIVES
levorphanol	methadone
	morphine sulfate SA/SR
NONPREFERRED BRAND NAME DRUGS	oramorph SR
Avinza (morphine sulfate ER)	
Duragesic (transdermal fentanyl)	
Kadian (morphine SR)	
Levo-Dromoran (levorphanol)	
MS Contin (morphine SR)	
Oxycontin (oxycodone ER)	

Drugs to treat headaches (Triptans)

NONPREFERRED BRAND NAME DRUGS	PREFERRED BRAND NAME ALTERNATIVES
Amerge (naratriptan)	Imitrex Injection (sumatriptan)
Axert (almotriptan)	Imitrex Nasal Spray (sumatriptan)
Frova (frovatriptan)	Maxalt (rizatriptan)
Imitrex tablets (sumatriptan)	
Maxalt MLT (rizatriptan)	
Zomig/ZMT (zolmitriptan)	

Diabetes & Endocrine Drugs

Sulfonylureas and Meglitinides

NONPREFERRED GENERIC DRUGS	PREFERRED GENERIC ALTERNATIVES
chlorpropamide	glyburide
tolazamide	glipizide
tolbutamide	
NONPREFERRED BRAND NAME DRUGS	
Amaryl (glimeperide)	
Diabenese (chlorpropamide)	

DiaBeta (glyburide)
Glucotrol (glipizide)
Glynase (glyburide micronized)
Tolinase (tolazamide)
Micronase (glyburide micronized)
Orinase (tolbutamide)
Prandin (repaglinide)
Starlix (nateglinide)

Estrogens

NONPREFERRED GENERIC DRUGS	PREFERRED GENERIC ALTERNATIVES
etradiol transdermal	estradiol oral/vaginal cream
estropipate	Preferred Brand Name Alternatives
	Menest (esterified estrogens)
NONPREFERRED BRAND NAME DRUGS	PremPro (conjugated estrogens/medroxyprogesterone)
Cenestin (synthetic conjugated estrogens)	
Climara (estradiol transdermal)	
Esclim (estradiol transdermal)	
Estrace oral (estradiol tablets)	
Estraderm (estradiol transdermal)	
Estring (estradiol vaginal ring)	
Femring (estradiol vaginal ring)	
Ogen (estropipate)	
Premarin oral/vaginal (conj. estrogens)	
Vagifem (estradiol vaginal tablets)	
Vivelle/DOT (estradiol transdermal)	

Gastrointestinal Medications

Proton Pump Inhibitors

NONPREFERRED BRAND NAME DRUGS	PREFERRED BRAND NAME ALTERNATIVES
Aciphex (rabepraxole)	Prilosec OTC
Nexium (esomeprazole)	Protonix (pantoprazole)
Omeprazole RX	
Prevacid (lansoprazole)	
Prilosec RX (omepraxole RX)	

Appendix III. - Prescription Drug Program Background Documents and Data

Cardiovascular Medications

HMG-CoA Reductase Inhibitors (Statins) to lower cholesterol

NONPREFERRED BRAND NAME DRUGS	PREFERRED GENERIC ALTERNATIVES
Lescol/XL (fluvastatin)	Lovastatin
Mevacor (lovastatin)	
Zocor (simvastatin)	**PREFERRED BRAND NAME ALTERNATIVES**
	Lipitor (atorvastatin)
	Pravachol (pravastatin)

Calcium Channel Blockers

NONPREFERRED BRAND NAME DRUGS	PREFERRED GENERIC ALTERNATIVES
Adalat/CC (nifedipine XR)	diltiazem/XR
Calan/SR (verapamil)	nifedipine/XR
Cardene/SR (nicardipine)	verapamil/XR
Cardizem/CD/LA/SR (diltiazem/XR)	
Cartia XT (diltiazem XR)	**PREFERRED BRAND NAME ALTERNATIVES**
Dilacor XR (diltiazem XR)	
Diltia XT (diltiazem XR)	
Dynacirc/CR (isradipine)	Norvasc (amlodipine)
Isoptin/SR (verapamil)	
Plendil (felodipine)	
Procardia/XL (nifedipine XR)	
Sular (nisoldipine)	
Taztia XT (diltiazem)	
Tiazac (diltiazem)	
Vascor (bepridil)	
Verelan/PM (verapamil)	

Beta Blockers

NONPREFERRED BRAND NAME DRUGS	PREFERRED GENERIC ALTERNATIVES
Cartrol (carteolol)	atenolol
Coreg (carevedilol)	bisoprolol
Corgard (nadolol)	carteolol
Inderal/Inderal LA (propranolol)	labetalol
Levatol (Penbutalol)	metoprolol
Lopressor (metoprolol)	nadolol

Normodyne (labetalol)	penbutolol
Tenormin (atenolol)	pindolol
Trandate (labetalol)	propranolol
Visken (pindolol)	
Zebeta (bisoprolol)	**PREFERRED BRAND NAME ALTERNATIVES**
	Toprol XL (metoprolol succinate)

Ace Inhibitors

NONPREFERRED BRAND NAME DRUGS	**PREFERRED GENERIC ALTERNATIVES**
Accupril (quinapril)	captopril
Aceon (perindopril)	enalapril
Capoten (captopril)	lisinopril
Lotensin (benazepril)	
Mavik (trandolapril)	**PREFERRED BRAND NAME ALTERNATIVES**
Monopril (fosinopril)	
Prinivil (lisinopril)	Altace (ramipril)
Univasc (moexipril)	
Vasotec (enalapril)	
Zestril (lisinopril)	

Genitourinary Medications

Drugs to treat urinary incontinence

NONPREFERRED BRAND NAME DRUGS	**PREFERRED GENERIC ALTERNATIVES**
Detrol/LA (tolterodine)	oxybutynin tablets/syrup
Ditropan/XL/syrup (oxybutynin)	
Oxytrol (oxybutynin transdermal)	
Urispas (flavoxate)	